CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13561	**Date: December 23, 2025**
	Change Request 14305

SUBJECT: Chapter 3 Sections 170-190 - General Overpayment Provisions - Update of Citations and Terminology Used

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 3 Overpayments. Specifically, this covers Section 170 'General Overpayment Provisions', 180 'Reserved', and 190 'Collection of Fee for Service Payments Made During Periods of Medicare Advantage (MA) Enrollment.

EFFECTIVE DATE: January 26, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 26, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/170/ General Overpayment Provisions
R	3/170/1/Offset of Part B Overpayments Against Other Benefits Due
R	3/170/2/When the Contractor Does Not Attempt Recovery Action
R	3/170/3/Information and Help Obtainable from the Social Security Office (SSO)
R	3/170/4/Recovery Where Physician or Other Individual Practitioner Is Deceased
R	3/170/5/Provider Offers to Settle on Compromise Basis
R	3/170/6/Unsolicited Overpayment Refunds
R	3/170/7/Timely Deposit of Overpayment Refund Checks
R	3/170/8/Informal Referral
R	3/190/Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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II. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide updated language to existing instructions within Chapter 3 Overpayments, Sections 170-190.

B. Policy: Overpayments are Medicare payments to a provider or beneficiary who received the amounts that are due and payable under the statute and regulations. Once a determination of an overpayment is made, the overpayment amount is a debt that the provider or beneficiary owes to the United States Government.

Under the Federal Claims Collection Act of 1966, as amended, each agency of the Federal Government (pursuant to regulations jointly promulgated by the Attorney General and the Comptroller General of the U.S.) must try to collect Federal Government claims that arise out of the agency's activities.

The Contractor will not be liable for overpayments it makes to debtors in the absence of fraud or gross negligence on its part. However, once a contractor determines an overpayment has been made, it shall attempt to recover the overpayments in accordance with the Medicare regulations, in accordance with 42 CFR 405.371.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14305.1	Contractors shall ensure they review manual documents to see the changes made to the referenced sections.	X	X	X	X					

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Financial Management Manual
Chapter 3 - Overpayments

Table of Contents
(Rev 13561.; Issued:12-23-2025)

Transmittals for Chapter 3

170- General Overpayment Provisions-

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

The general overpayment provisions mentioned in this section are important to the overpayment collection process but *cannot* be categorized into another section. Some of these provisions require input from other manual instructions and are only briefly mentioned in this manual. When necessary, another manual reference has been cited for additional information.

170.1- Offset of *Part B* Overpayments Against Other Benefits Due –

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

Benefits Payable Under Part B - Where the *Contractor* determines that a Part A overpayment has been made to a provider on behalf of a beneficiary, it shall ascertain whether the beneficiary is entitled to any Part B payment for the services in question. (*See IOM 100-02,* Medicare Benefit Policy, Chapter 6 *(Hospital Services Covered Under Part B)*. If it appears that Part B benefits are payable, it shall arrange for billings under Part B. It shall use any Part B benefit as an offset against the Part A overpayment.

A. Use of Lifetime Reserve Day *Under Part A* -

If a Part A overpayment for which a beneficiary is liable was caused by payment for services rendered after exhaustion of benefit period days, the *Contractor* shall reduce the amount of the overpayment by the application of the beneficiary's lifetime reserve days, unless the individual elected not to use them. An individual who has been overpaid for services rendered after exhaustion of benefits can elect not to use reserve days only if the individual refunds the overpaid amount. (See *100-02* Medicare Benefit Policy, Chapter 5, *Lifetime Reserve Days*.)

170.2 - When the *Contractor* Does Not Attempt Recovery Action

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

The *Contractor* shall not attempt recovery action on individual overpayments if:

A. Total Overpayment Less Than *$25*

The cost of recovering such a small amount ordinarily exceeds the amount recovered. However, the *Contractor* shall accept unsolicited overpayment refunds regardless of the amount. See *Chapter 4, Debt Collection §700.16* for termination of collection action procedures.

B - The *Contractor* Has Not Taken Action to Reopen the Payment Decision Within Four Years (48 Months) after the Date of the Initial Payment Determination

Unless fraud or similar fault is present, a payment determination may not be reopened where the *Contractor* has not taken *any* action (which can be documented) questioning the correctness of the determination within 4 years (48 months) after the date the initial determination was approved. (See *IOM 100-04* Medicare Claims Processing, Chapter *34, Reopening and Revision of Claim*

Determinations and Decisions, §10.6 for policies governing the reopening and revision of decisions to allow or disallow a claim.)

C - Payments to Providers for Medically Unnecessary Services or Custodial Care Where Waiver of Liability Applies

Where both the beneficiary and provider were without fault (see *IOM 100-04,* Medicare Claims Processing, Chapter 30, *Financial Liability Protections*), the *Contractor* shall waive liability for the overpayments.

170.3- Information and Help Obtainable from the Social Security Office (SSO)

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

Occasionally, it may be possible for the *Contractor* to get information or help from the local SSO. For instance, if the beneficiary has moved, the SSO may know the new address, or if the beneficiary has died, it may know the administrator of the estate. If the beneficiary takes a check representing an incorrect payment to the SSO, the SSO forwards the check to the *Contractor*. However, the *Contractor* shall not ask the SSO to collect, or indirectly aid in, the collection of an overpayment. - Recovery Where Physician or Other Individual Practitioner Is Deceased –

170.4 - Recovery Where Physician or Other Individual Practitioner Is Deceased

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

Where a physician or other individual practitioner who is liable for an overpayment dies, the overpayment should be withheld from other Medicare payments due their estate. If recovery is not possible by recoupment, the *Contractor* shall ascertain whether an administrator or executor has been appointed and then send a letter to the estate of the decedent at the address of the legal representative, if known, or the last known address of the deceased.

If the reply to the letter indicates that the estate will not refund the overpayment, or if a reply is not received within 30 days, the case should be forwarded to CMS for possible litigation. When *referring to* such overpayments, the *Contractor* shall include any information about the appointment of a legal representative, the size of the estate, etc., and copies of any correspondence with survivors or others concerning the overpayment.

170.5-Provider Offers to Settle on Compromise Basis

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

An overpaid provider may offer to compromise *the overpayment*. The *Contractor* shall forward compromise offers to the *CMS only* when further collection efforts would be unproductive and would not benefit the Medicare Program.

170.6 - Unsolicited Overpayment Refunds

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

When a provider believes that an overpayment has been received and makes an unsolicited refund, the *Contractor* accepts it regardless of the amount. All documentation submitted with the unsolicited refund should be forwarded to the correct department. (*See IOM 100-08, Medicare Program Integrity Manual, Ch. 4, § 4.2.2.8.1.3* for unsolicited refunds related to an outstanding fraud investigation.)

170.7- Timely Deposit of Overpayment Refund Checks

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

Promptly deposit all refund checks into the Medicare "Federal Health Insurance Benefits Account". The *Contractor* shall credit all such deposits on the day following the date of receipt in its mailroom or initial point of entry. (It shall *be credited* within 2 days if the bank is not located in the same city as the *Contractor*.). (See *IOM 100-06, Ch.5, Financial Reporting*, §100.3 *Establishment of Accounting Records*)

170.8– Informal Referral

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

For Medicare overpayment purposes, a referral is a request to the *Center for Medicare and Medicaid Services (CMS)* for assistance in an overpayment. This may be for a waiver determination, a termination request, a request for technical assistance, a referral to the Department of Justice, or any other aspect of the debt collection process. The referral may be in the form of an email, phone, fax, or written correspondence. Any referral to the *CMS* should occur before the debt is eligible to be referred to the Department of Treasury. If changes occur to the debt during the referral process, the *Contractor* should immediately notify *CMS.*

Note: *Section 140, Exhibit-1* includes a referral checklist that *Contractors* should utilize *when* necessary.

190 – Collection of Fee-for-Service Payments Made During Periods of Medicare Advantage (MA) Enrollment

(Rev 13561.; Issued:12-23-2025: Effective: 01-26-2026, Implementation: 01-26-2026)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use HICN as part of their processes.

Effective October 1, 2003, Common Working File (CWF) implemented the informational unsolicited response edit based on the same coding files made available for the reject edits in the risk-based MA Enrollment coding files described in the CWF System Documentation at:
https://www.medicaremaintainer.com/cwfm.aspx

Upon receipt of notification that a beneficiary has previously enrolled in a MA Plan and the enrollment is posted to the CWF, the CWF will search claims history to determine whether any fee-for-service claims were erroneously approved for payment during a period of retroactive MA enrollment. The CWF compares the period between the MA enrollment start date and the date of service of the claims in history. Services that fall within the responsibility of the MA Organizations are identified.

The CWF generates an Informational Unsolicited Response (IUR) with trailers 05 & 24 containing the identifying information regarding the claim subject to the *risk-based* MA payment rules. The IUR has all necessary information to identify the claim including the Internal Control Number or the Document Control Number, and the Medicare beneficiary identifier. The CWF electronically transmits the IUR to the Contractor that originally processed the claim. The IUR is included in the existing CWF response file. The IURs in that file for claims to be adjusted are identified with a unique transaction identifier. The previously submitted claim is not canceled and will remain *in* the CWF paid claims history file, pending subsequent adjustment.

Upon receipt of the IUR the Shared System software reads the trailer for each claim and either a manual or automated adjustment is performed. The contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payment and must generate an adjustment to update or cancel the claim to update CWF and contractor history.

Part B

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the contractor in trailer 11. Contractors are to recover any monies due back to Medicare resulting from these denials, by following the standard or (customary) recovery process. Contractors are also responsible for providing the M/A plan number to the providers in their correspondence.

In the event that a denial is reversed upon appeal, the Group Health Organization (GHO) override code of '1' must be used to allow payment.

Part A

When CWF receives an adjustment for the fee-for-service claim on history, the deductible is updated on the beneficiary's file, and the corrected deductible information is returned to the contractor in trailer 11. To recover any monies *due* to Medicare resulting from these denials, claims are to be *adjusted*, and overpayments are recovered through the customary recovery process.

In the event that a denial is reversed upon appeal, a 1-byte override field is created at the header level for claims. The *Contractors* use the override code "1" in this field for adjustments to all inpatient claims, including home health. For an Outpatient Denial with a 'N' No Pay Code, use a value of '2' in the HMO override field. The purpose of using "1" or "2" is to by-pass the CWF edit, which allows no changes to the amount initially paid for claims.

Messages To Be Used With Denials Based On Unsolicited Response

The following messages should be used when the contractor receives a reject code from CWF indicating that the services were rendered during a period when the beneficiary was enrolled in a MA, and billing should have been submitted to the Managed Care Plan for payment.

Remittance Advice

At the claim level, report adjustment reason code 24 - Payment for Charges Adjusted. Charges are covered under a capitation agreement/managed care plan.

Information to be made available to providers via letter (or an *alternative* method).

Language for Contractors to Use in Letter to Provider

Part A
The plan number is not required for contractor communications. Those providers are to determine which plan to contact through an eligibility inquiry or by contacting the beneficiary directly.

Part B

This beneficiary was enrolled in [Plan Alpha Numeric ID], a *risk* based managed care organization, for the date of service of this claim. You must contact the Managed Care organization for payment for these services. A list that provides the MCO name and address associated with the MCO number is available on the CMS Internet at:

http://www.cms.hhs.gov/HealthPlansGenInfo/claimsprocessing20060120.asp#TopOfPage.